EXHIBIT A



APPLICATION FOR LIFE INSURANCE

PART 1

PART 1		
Pruco Life insurance Company		3
The Prudential Insurance Company of America Both are Prudential Financial companies.		
Corporate Offices, Newark, New Jersey	POLICY NUMBER	(IF KNOWN): <u>19201428</u>
A. PROPOSED INSURED (POLICY OWNER UNLESS SECTION DIS	COMPLETED)	
1. Name: SASIKALA NARRA		
2. Previous name (if changed in the last 5 yrs.):		
2 Social Cocurity number. REDACTED	A State of birth (Country if not	
5. Gender: Demale DMale 6. Date of birth	ED <u>1978</u> 7. Date policy	to Save Age? □Yes ØNo
8. Are you a permanent, legal US resident? 🗹 Yes 🗆 No		42
If No, provide country of legal residence, type and number of vi	sa, expiration date and length o	of US residence :
9. Driver's license issuing state: NU Number RED.	ACTED	Expiration date: 08/12/2015
If None, why not?:		
10. Residence address (No PO boxes): Street HAMILTON ROAD		Apt <u>3D</u>
City MAPLE SHADE	State <u>NU</u>	ZIP <u>08052</u>
11. e-mail address: HANUMANTHARAO.NARRA@GMAIL.COM		
12. Home telephone number: (718) 496-5497	Business telephone number (e	kt.): <u>(979) 691-7700</u>
13. Current employer name: COGNIZANT TECHNOLOGIES		
Business address: Street 211 QUALITY CIR		Suite
City COLLEGE STATION	State <u>TX</u>	ZIP <u>77845</u>
14. Occupation: SENIOR ASSOCIATE		_
Duties: Working as System analyst and Making Developm		
	annual income \$ 0	Net worth \$_750.000
B. PLAN OF INSURANCE		
1. Amount of insurance applied for: \$ 500,000 Com	nplete <i>Financial Supplement</i> wit	h face amounts of \$5,000,000 or more up to
age 70, \$2,500,000 or more ages 71-80, \$1,000,000 or more a 2. Product applied for:	iges 81 and up.	
Z. Product applied for: IZI Term Essential®: □10 □15 □20 IZI30	□Prul ife® Index Ad	vantage (IAUL) Complete the IAUL Supplement.
□ Term Elite®: □10 □15 □20 □30	□ PruL fe [®] Universa	
□ ROP Term: □15 □20 □30		I Protector (UL Protector)
□ PruTerm WorkLife 65 st (includes Insured's Waiver of Premium		ULP) Complete the Variable Supplement.
☐ Prulife®Custom Premier II (PCP II) Complete the Variable S		
☐ PruLife® Founders Plus (PFP) Complete the PFP Supplement	nt.	
3. For UL and VUL products only: Death Benefit type: 🏻 Type A (L		
☐ Type C (Return of Premium) —	NVA for IAUL, UL Protector & VUI	LP. — Interest rate:%
4. For UL and VUL products only: Definition of life insurance:		
☐ Cash Value Accumulation Test (CVAT) ☐ Guideline Premiur		
5. Requested Optional Bénéfits: (Not all benefits are available for all		
☐ Waiver of Premium/Enhanced Disability Benefit	Overloan Protection	
☑ Acceleration of Death Benefit (Living Needs Benefit)	· ·	lete Child Rider Supplement.
□ Accidental Death Benefit: Amount \$		
☐ BenefitAccess Rider Complete Benefit Access Rider Supple		**
- Other Riders/Benefits (indicate amount where applicable):		
C. PREMIUM		
1. Send notices (check one): 🗷 Policyowner 🗆 Other recipient:	·	
Send notices (check one): ☑ Policyowner's residence ☐ Other a	ddress:	
Street		Apt
City	State	ZIP
2. Premium payment mode: Annual Semiannual Quai 3. For non-term plans, billed premium: \$	rterly 🔲 Monthly — Electronic F	unds Transfer

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D. OWNER (COMPLETE IF OWNER IS OTHER THAN T	THE PROPOSED INSURED)					
or multiple owners, details are to be listed in Special Re	quests, section H.					
Name of owner:						
2. Social Security/Tax identification number (SSN/TIN):						
Residence address (No PO boxes): Street					Apt	
- City-	State		ZiP .			
. Owner's email-address:		<u>-</u>				
ia. For trust owner: Complete the Trustee Statement a	and Agreement (COMB 8604	4).				
Trust date:/	14.7					-
Trustee(s)						
Trustee(s) Irrevocable □ Quality	fied Retirement Plan Trust	□ Welfare Ben	efit Trust			
5b. For business owner: Complete the Business Supple						
Form: Corporation Partnership	☐ Sole proprietorship	□ Other:			- 17	
S Corporation Silc	□ Tax exempt					
ic. For personal owner:						
Total insurance program: Currently in-force: \$		Pending application	ations: \$			
Relationship to Proposed Insured:			_Date of birth:	/	1	
Earned annual income: \$	Unearned annual income: \$_		Net w	orth: \$		
E. BENEFICIARY DETAILS	4					
f insurance is for business purposes, also complete the	Business Insurance Suppleme	ent. If beneficiary	is a trust, prov	ide name of tru	st and trustee	(s),
date of trust and if trust is revocable or irrevocable. If b	eneficiary is a business, pleas	e list name of bu	isiness, city and	l state where lo	cated and the	
form of business. Name: First Middle Last	Relationship to	Proposed Insure	а Аре	Beneficiary C	lass	
Janie: Liist Minnie Fast	noid (ibilonip to	Tropossa moare	• ,,,,,,	*	condary/Conti	ngent
ALE ODENIAL REQUESTS					a	Bai
SEE SPECIAL REQUESTS				<u> </u>		
	4 H U N				<u> </u>	
F. INSURANCE HISTORY						
1. Do you have any existing life insurance or annuities	?				☐ Yes 1	DI No
Note: Existing coverage includes any life insurance		ed, sold or trans	ferred.			
2Will this insurance replace* any existing insurance		5			☐ Yes 1	IXI No
3. List the following details for all existing coverage. (ed*, list all in fo	rce life insuran	:e);		
Insurance Company	Face Amount	Туре	Product	To Be Replaced	12* 1035 Exch	ange'
		C Contra	C Annuitu	To be replaced	i. 1000 Excil	ango.
1 a	\$	□ Individual	□ Life	☐ Yes ☐ No	🗆 Yes 🗅	No
		☐ Group	□ Annuity	- V 1	, V	Mt_
75 Test Test Test Test Test Test Test Test	*	□ Individual	□ Life	☐ Yes ☐ No	□ Yes □	INO.
	\$	☐ Group	☐ Annuity	☐ Yes ☐ No	□ Yes □	Nn
	Y	☐ Individual ☐ Group	□ Life □ Annuity	_ 100 _ 110	D 150 D	110
	\$	□ Individual	□ Life	☐ Yes ☐ No	☐ Yes ☐	No
		☐ Group	☐ Annuity			
	٤	□ Individual	□ Life	☐ Yes ☐ No	□ Yes □	No
*Replace or replaced means that the insurance bei	ng anolied for may replace or	rause a change i	in anv existing i	neiltance ot ani	uity with any	
company, including the lapse or surrender of the e	xisting policy, or the use of fu	nds or values fro	m the existing o	olicy to pay for	he new policy	
4. Are you applying for or reinstating life insurance wi				, to pay it.	□ Yes	
If Yes, give company name, amount applied for		ed including th	is annlication		— 103	110
77-54, Brito dompon, manie, dindante applica for				·		
5. Have you had life or health insurance declined, pos	*	•	nium?		□ Yes	DO No
If Yes, give company name, type of insurance, d	ate, action taken and reaso	of for action :		- 0		
12 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1				įa.		
					(CONTINUED)	

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F.	INSURANCE HISTORY (CONTINUED)		
6.	Is the proposed insured or proposed owner considering the transfer or sale to a life settlement company or other investor of: policy ownership; or, any interest in the policy benefits, either directly as a named beneficiary or indirectly as a beneficiary		
į	or owner of a trust or other entity? If Yes, provide details:	□ Yes	☑ No
•		- 19	
C	GENERAL INFORMATION		
	In the past five years, have you flown as a pilot, student pilot or crew member or do you intend to become a pilot? In the past five years, have you participated in any activities such as motorized vehicle racing, SCUBA diving, mountain climbing, skydiving, extreme sports such as BASE jumping, bungee jumping or cave exploration, or do you intend to?	□ Yes □ Yes	
	If Yes, to Question 1 or 2 above, complete the appropriate Supplement.		- 44
3	Have you ever used tobacco or any other nicotine products such as cigarettes, cigars, pipe, chewing tobacco, snuff, nicotine gum or nicotine patch? If Yes, provide details:	□ Yes	120 No
18	Product Type(s) Date Last Used Frequency of Use		
35			
4.	In the past five years, have you.		
100 100	a. had your driver's license denied, suspended or revoked?	□ Yes	IZI No
	b. been convicted of or pled guilty to driving under the influence of alcohol and/or drugs? c. been convicted of or pled guilty to any moving violations?	□ Yes	DO No-
		☐ Yes	DSI No "
	Within the past 10 years, have you been arrested, convicted, or imprisoned for any crime and/or are you currently awaiting trial for any crime?	□ Yes	em Ala
	Will you live or travel outside the United States within the next 12 months?	1.196	DE No
	Details required include location (city/country), frequency, duration and purpose of each trip.	☐ Yes	F\$1 1AO
7	Give complete details of any "Yes" answers for questions 4 — 6, including question number and appropriate details:		
•	Question # Details		
			No. Post 17th
17			
		310	
	<u> </u>		
í	I. SPECIAL REQUESTS		
(C	lass 1) - Hanumantharao narra , Husband , 36 :(Class 2) - Children of the Insured in Equal Shares or to the Su	RVIVOR(S)	
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PART 2		
A. PERSONAL PHYSICIAN INFORMATION		
Name <u>Surendra Sheth</u>		37
Address: Street 526 LIPPINCOTT DR Suite		
City MARLTON State NU ZIP 08053		
Telephone-number: (856) 985-3700 Date last seen: 09/2014 Reason last seen: GENERAL CHECK UP		
If more than one personal physician, provide details in section D number 6.		·
B. PHYSICAL MEASUREMENTS	L	-0 -2
1. Height: 5 feet 4 inches Weight: 176 pounds 2. Within the last 12 months, have you had a change of weight (gain or loss) of more than 10 pounds?	□ Yes	TVI No
If Yes, provide details:	163	121 140
C. FAMILY HISTORY		
1. Have any immediate family members (mother, father, brother, sister) been diagnosed with or died from coronary artery disease,	- v.	
cerebrovascular disease, diabetes or cancer before age 70?	☐ Yes	EXI IVO
If Yes, provide details including which member and medical condition, age at diagnosis, and age at death (if applicable) :		
and a substitute of the substi		
2. Father: Current age 64 or Age at death: Mother: Current age 62 or Age at death:		
D. MEDICAL INFORMATION		
Has a member of the medical profession ever treated you for or diagnosed you with:		
a. high blood pressure, chest pain, a heart attack, coronary artery disease, a heart valve disorder, a heart murmur, an irregular		
heart beat, cerebrovascular disease, a stroke, circulatory disease, an aneurysm or any disease of the heart or blood vessels?	☐ Yes	₩ No
b. anemia or other abnormality of the blood (other than HIV)?	☐ Yes	III No
c. a polyp, cyst, tumor, cancer, leukemia, melanoma, lymphoma or Hodgkin's disease?	☐ Yes	🖾 No
d. diabetes, high blood sugar, glucose intolerance or other endocrine disorder?	☐ Yes	🖾 No
e. anxiety, depression, or any other mental or psychiatric illness?	☐ Yes	III No
f: Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or any other sexually transmitted disease		
(other than HIV)?	TYes	⊠ No
g. asthma, emphysema, cystic fibrosis, sleep apnea, sarcoidosis, tuberculosis or any other disorder of the lungs	- V	om Ala
or respiratory system?	□ res	IXI No
-h. a seizure, epilepsy, multiple scierosis, Parkinson's disease, muscular dystrophy, cerebral palsy, paralysis, Alzheimer's disease or any other disorder of the brain or nervous system?	□ Ves	DI No
i an ulcer, hepatitis, cirrhosis, pancreatitis, ulcerative colitis, Crohn's disease or any other disorder of the esophagus, liver,	□ 1€3	III 140
stomach or intestines?	☐ Yes	DD No
j. – nephritis, polycystic kidney disease or any other disorder of the bladder, kidney, urinary tract or prostate?		DI No
k. arthritis, gout, back trouble, or any disease or disorder of the joints, muscles or bones?	□ Yes	DI No
I. lupus, rheumatoid arthritis, chronic fatigue syndrome, fibromyalgia, or any other disease or disorder of the autoimmune system	? 🗆 Yes	EE No
2. Have you ever used:		
a cocaine, crack, marijuana, heroin, Ecstasy, PCP, LSD, methamphetamine, any other hallucinogenic drug or controlled substance	? □ Yes	Mo No
b. amphetamines, barbiturates, sedatives, opiates or methadone, or controlled substance except as prescribed by a physician?	🗆 Yes	🖾 No
3. Have you had or been advised to have treatment or counseling for alcohol or drug use or been asked to reduce or eliminate		
their usage?	□ Yes	DO No
4. Other than what has already been disclosed, within the past 5 years, have you:		
a - requested or received disability or compensation benefits?	☐ Yes	DB No
b. been a patient in a hospital or other medical facility, other than for normal childbirth?		DO No
c. had any other disease, disorder or condition?		DO No
d. been advised to have surgery, medical tests or diagnostic procedures (other than for HIV)?	☐ Yes	DD No
5. Are you currently receiving medical treatment or taking any other medication or herbal supplement that has not already	- V	mer At-
been disclosed?		20 No
	ONTINUE!	
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are compic	te details of any	"Tes answers	tor questions 1-	5, including: Qu	estion number, diagnosis, da	ite of onset and recovery,
nedication	treatment pres	cribed and the	e name, addres	s and telephone	number of all attending phy	sicians and hospitals.
14.1.40	47.542 #-		Date of	Date of	Medication/	Physician/Hospital
uestion #	Diagnosis	1	Onset	Recovery	Treatment Prescribed	Name, Address & Phone Numbe
	5A 8 8			,		, , , , , , , , , , , , , , , , , , , ,
						
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AGREEMENTS

By signing this form, I have carefully reviewed the application including all supplements attached to the policy, and I agree to the following:

To the best of my knowledge and belief, the statements in this application are complete, true and correctly recorded.

- Except for failure to pay premium, the validity of this policy will not be contested after it has been in force during the insured's lifetime for two years
 from the date it takes effect.
- If I have requested the Acceleration of Death Benefits (Living Needs Benefit), I have read the disclosures in the Living Needs Benefit brochure.
- My original signature has been affixed to this application, the original will be retained by the Company named at the beginning of this application ("Company"). The copies attached to the policy issued to me are identical in form and substance.

Any policy issued on this application shall not take effect until after all of the following conditions are met:

- A payment equal to the full first required premium is received by the Company within the lifetime of the proposed insured. A payment will only be
 considered to be received if one of the following valid items is received by the Company: (i) a check in the amount of the full first required
 premium; (ii) a completed and signed payment form for the first full premium; or (iii) any other form of payment acceptable to the Company.
- The form of payment submitted is honored. If payment is made by credit/debit card, wire transfer or automatic bank draft, no premium is
 considered to be honored until the Company actually receives the funds unless otherwise provided by applicable law.

A signed copy of this Application is received by the Company.

- The Owner has personally received the policy during the lifetime of and while the health of the Proposed Insured is as stated in this application.
- Only an officer of the Company with the rank or title of Vice President may make or alter any contract or agree not to enforce any of the rights of
 the Company, and then only in writing. No producer or medical examiner is authorized to accept risks, pass on insurability, make or after
 contracts, or waive any of the other rights or requirements of the Company. Notice to or knowledge imputed to any producer or medical examiner
 will not be notice of or knowledge to the Company unless it is set out in writing in this application.

FRAUD WARNING

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

SIGNATURES				
Owner's Tax Certification (check	boxes ON	LY if applicable):		
a U.S. person (including residen I have been notified by the lo	t aliën), a nternal Re iding resid	nd I am not subject to be evenue Service that I am	ackup withholding under Sect subject to backup withholdin	n this form is my correct TIN. I further certify that I ar tion 3406(a)(1)(C) of the Internal Revenue Code. Ig due to the underreporting of interest or dividends B (BEN, BEN-E, EC), EXP or IMY). In most cases, Form
The			ot require your consent to a ations required to avoid bac	ny provision of this document kup withholding.
Signed at (STATE) NEW JERSEY	14.00		on (DATE)	09/05/15
Signature of proposed insured	X _	Santale		
If policyowner is different from t	he propos	sed insured:		
For a personal policyowner(s):				
Signature of policyowner(s)	X			
For an entity policyowner(s) (i.e., to Name of entity	ru <u>st, b</u> us <u>i</u> i	ness):		
Signature of officer/trustee(s)	X			
Tiss of Affice December 1.1		_		
Title of officer/trustee(s)		$\sim \prime$		

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EXHIBIT B



APPLICATION FOR LIFE INSURANCE

PART 1

X	Pruco	Life	Insurance	Com	Dany
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☐ The Prudential Insurance Company of America

Both are Prudential Financial companies.

Congrate Offices, Newark, New Jersey

Corporate Offices, Newark, New Jersey	POLICY NUMBER (IF KNOWN): V2353442
A. PROPOSED INSURED (POLICY OWNER UNLESS SECTION D IS COM	PLETED)
1. Name: SASIKALA NARRA	
2. Previous name (if changed in the last 5 yrs.)	
3. Social Security number REDACTED 4. S	State of birth (Country if not U.S.): INDIA
	1978 7. Date policy to Save Age? □Yes ☑No
8. Are you a permanent, legal US resident? @Yes 🗆 No	
If No, provide country of legal residence, type and number of visa, ex	xpiration date and length of US residence :
9. Driver's license issuing state: W Number:	Expiration date: <u>08/12/2015</u>
If None, why not?:	
10. Residence address (No PÔ boxes): Street HAMILTON ROAD	Apt 3D
City MAPLE SHADE	State N / ZIP 08052
11. e-mail address: Hanumantharao Narra@GMAIL COM	
	usiness telephone number (ext.): (979) 691-7700
13. Current employer name: COGNIZANT TECHNOLOGIES	rainess telephone mathibes text./. (373) 631 7766
Business address: Street 211 QUALITY CIR	Suite
City COLLEGE STATION	
a sold and a sold and a sold a	State IA Zir 17043
14. Occupation: SENIOR ASSOCIATE	ACCOUNTE TO DUCKIESE DECITIONALISE
Duties: WORKING AS SYSTEM ANALYST AND MAKING DEVELOPMENT A	
15. Earned annual income \$ 94,000 Unearned annua B. PLAN OF INSURANCE	al income \$_0Net worth \$_750,000
1 Amount of insurance applied for: \$ 500,000 Complete age 70, \$2,500,000 or more ages 71-80, \$1,000,000 or more ages 8	e <i>Financial Supplement</i> with face amounts of \$5,000,000 or more up to
	at and up.
2. Product applied for: ☐ Term Esśeritial®: ☐ 10 ☐ 15 ☐ 20 ☐ 30	□ PruLife [®] Index Advantage (IAUL) Complete the <i>IAUL Supplemei</i>
□ Term Elite®: □10 □15 □20 □30	□ PruLife® Universal Plus (UL Plus)
□ ROP Term: □15 □20 □30	☐ PruLife® Universal Protector (UL Protector)
☐ PruTerm WorkLife 65 ^{ss} (includes Insured's Waiver of Premium Benef	
☐ PruLife® Custom Premier II (PCP II) Complete the Variable Supple	int Dither
Prulife®Founders Plus (PFP) Complete the PFP Supplement.	ement, in other:
3. For UL and VUL products only: Death Benefit type: Type A (Level)	□ Type 8 (Variable) - N/A for III. Protector
	for IAUL, UL Protector & VULP. — Interest rate:%
4. For UL and VUL products only: Definition of life insurance:	of around the roll . Interest rate.
Cash Value Accumulation Test (CVAT) ☐ Guideline Premium Test	et (CPT)
5. Requested Optional Benefits: (Not all benefits are available for all produ	
☐ Waiver of Premium/Enhanced Disability Benefit	Overloan Protection Rider
☐ Acceleration of Death Benefit (Living Needs Benefit)	☐ Child Rider Complete Child Rider Supplement.
□ Accidental Death Benefit: Amount \$	□ Automatic Premium Loan
BenefitAccess Rider Complete Benefit Access Rider Supplement	
	LI Elitaticed Cash value Rider
Other Riders/Benefits (indicate amount where applicable):	
C. PREMIUM	
1. Send notices (check one): ☑ Policyowner ☐ Other recipient:	
Send notices (check one): Policyowner's residence Other address	
Street	
City	Apt Apt ZIP
2. Premium payment mode: ☐ Annual ☐ Semiannual ☐ Quarterly	State ZIP
3. For non-term plans, billed premium: \$ 248.00	m mounty - electronic entry Hauster
o. Tot non-term pians, pillen pietilitilis; @ 270,00	8
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D. OWNER (COMPLETE IF OWNER IS OTHER TI	HAN THE PROPOSED INSURED)					
For multiple owners, details are to be listed in Spec				-	200	
1. Name of owner:						
2. Social Security/Tax identification number (SSN	VTIN):				5 25 <u>-</u> 2	
3 Residence address (No PQ boxes); Street				(9-1)	Apt	
Ĉity	Sta	te	Z	IP .		
4. Owner's email address:						
5a. For trust owner: Complete the <i>Trustee Statem</i>	tent and Agreement (COMB 860	44).				
Trust date: / /						
Trustee(s)						
Type: ☐ Revocable ☐ Irrevocable ☐	Qualified Retirement Plan Trust	□ Welfare Ber	efit Trust			
5b. For business owner: Complete the Business S	Supplement.					
Form: Corporation Partnership	□ Sole proprietorship	□ Other:				
□ S Corporation □ LLC	□ Tax exempt			1		
5c. For personal owner:						
Total insurance program: Currently in-force: \$_						
Relationship to Proposed Insured:			_ Date of bir	th:	/	
Relationship to Proposed Insured: Earned annual income: \$	Unearned annual income: \$		Ne	t worth: \$		
E. BENEFICIARY DETAILS						
If insurance is for business purposes, also complet	te the Rusiness Insurance Supplem	ent. If benefician	is a trust. o	rovide name of trust	and truste	ee(s).
date of trust and if trust is revocable or irrevocable form of business. Name: First Middle Last		o Proposed Insure		and state where loca ge Beneficiary Cla		ne
	100 000000			Primary Seco		ntingent
SEE SPECIAL REQUESTS						80
SEE OF LORIE HE GOE 515						
*						
		··				
F. INSURANCE HISTORY						
1. Do you have any existing life insurance or ann					☐ Yes	™ No
Note: Existing coverage includes any life insur		ned, sold or trans	sferred.			
2. Will this insurance replace* any existing insur					☐ Yes	⊠ No
3. List the following details for all existing covers	age. (List only annuities to be repla	iced*, list all in fo	orce life insur	ance):		
Insurance Company	Face Amount	Туре	Product	To Be Replaced?	* 1035 Ex	change
	•	☐ Group	☐ Annuity	☐ Yes ☐ No	□ Vos	CT Ala
		lndividua)	□ Life		D les	III NO
	\$	☐ Group - ☐ Individual	☐ Annuity ☐ Life	☐ Yes ☐ No	☐ Yes	□ No
		□ Group	☐ Annuity			
- 15 - 12 - 12 - 12 - 12 - 12 - 12 - 12	<u> </u>	· 🖒 Individual	□ Life	□ Yes □ No	☐ Yes	□ No
9 99 .4 14 4 4		☐ Group	Annuity	□ Yes □ No	□ Yes	
10 10 10 10 10 10 10 10 10 10 10 10 10 1	V 10 20	- □ Individual □ Group	☐ Life ☐ Annuity		F 162	 110
	\$. 🗆 Individual	Life	☐ Yes ☐ No	☐ Yes	□ No
*Popless or motored	an baing analisal day was and			_ l		
*Replace or replaced means that the insurant company, including the lapse or surrender of						
4. Are you applying for or reinstating life insurar		ilius oi values ilu	III THE EXISTIN	g poncy to pay for th		cy. DEINO
If Yes, give company name, amount applie		red including th	ic annlicati	op .	LJ IKS	LES PHO
gire vompany name, amvain applie	a in aus mes emonic to no his	utriuuing (f	ns applicati			
			<u>-</u> ,			
5. Have you had life or health insurance declined	d, postponed, rated or issued with	an increased prer	nium?		☐ Yes	DO No
If Yes, give company name, type of insuran						
in the state of th						
			_			
	· · · · · · · · · · · · · · · · · · ·		-			
				(0	CONTINUE))

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policy ownership; or, any interest in the policy benefits, either directly as a named beneficiary or indirectly as a beneficiary or owner of a trust or other entity? Yes No.	F. INSURANCE HISTORY (CONTINUED)		
In the past five years, have you flown as a pilot, student pilot or crew member or do you intend to become a pilot? In the past five years, have you participated in any activities such as notorized vehicle racing, SCUBA diving, mountain climbing, styloffing, externs sports such as BASE jumping, Jourgee jumping or cave exploration, or do you intend to? If Yes, to Question 1 or 2 above, complete the appropriate Supplement. Have you ever used tobecco or any other nicotine products such as cigarettes, cigars, pipe, chewing tobacco, snulf, ricotine gum or nicotine patter? If Yes, provide defails: Product Type(s) Date Last Used Frequency of Use In the past five years, have you. 3. had your driver's iteritie denied, suspended or revoked? 5. been convicted of or pide guilty to driving under the influence of alcohol and/or drugs? C. been convicted of or pide guilty to any moving violations? Within the past 10 years, have you been airested, convicted, or imprisoned for any crime and/or are you currently awaiting trial for any crime? Within the past 10 years, have you been airested, convicted, or imprisoned for any crime and/or are you currently awaiting trial for any crime? Yes © No Will you live or travel outside the United States within the next 12 months? Petals: required include location (city/country), frequency, duration and purpose of each trip. Give complete details of airy "Yes" answers for questions 4 – 6, including question number and appropriate details: Question # Details H SPRECICA RUGUESTS OLD THE SURVIVOR(S)			m Na
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If Yes, to Question 1 or 2 above, complete the appropriate Supplement. Have you ever used tobacco or any other incidine products such as cigarettes, cigars, pipe, chewing tobacco, snuff, nicotine gun or incidine patch? If Yes, provide details: Product Type(s) Date Last Used Frequency of Use In the past five years, have you: a. had your driver's licenize denied, suspended or revoked? b. been convicted of or pled guilty to driving under the influence of alcohol and/or drugs? Within the past 10 years, have you been airested, convicted, or imprisoned for any crime and/or are you currently awaiting trial for any crime? With you live or travel outside the United States within the next 12 months? Will you live or travel outside the United States within the next 12 months? Details required include location (city/country), frequency, duration and purpose of each trip. Give complete details of any "Yes" answers for questions 4 – 6, including question number and appropriate details: Question # Details H. SPECIAL REQUESTS WILLIAMS (Class 1) - HANUMANTHARAQ NARRA , HUSBAND , 36 :(Class 2) - CHILDREN OF THE INSURED IN EQUAL SHARES OR TO THE SURVIVOR(S)	In the past five years, have you flown as a pilot, student pilot or crew member or do you intend to become a pilot? In the past five years, have you participated in any activities such as motorized vehicle racing, SCUBA diving, The past five years, have you participated in any activities such as motorized vehicle racing, SCUBA diving, The past five years, have you participated in any activities such as motorized vehicle racing, SCUBA diving, The past five years, have you participated in any activities such as motorized vehicle racing, SCUBA diving, The past five years, have you participated in any activities such as motorized vehicle racing, SCUBA diving, The past five years, have you participated in any activities such as motorized vehicle racing, SCUBA diving, The past five years, have you participated in any activities such as motorized vehicle racing, SCUBA diving, The past five years, have you participated in any activities such as motorized vehicle racing, SCUBA diving, The past five years, have you participated in any activities such as motorized vehicle racing, SCUBA diving, The past five years, have you participated in any activities such as motorized vehicle racing, SCUBA diving, The past five years, have you participated in any activities such as motorized vehicle racing, SCUBA diving, The past five years, have you participated in any activities such as motorized vehicle racing, SCUBA diving, The past five years, have you participated in any activities such as motorized vehicle racing, SCUBA diving, The past five years, have you participated in any activities such as motorized vehicle racing, and the past five years, have you past five years, have		
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nicotine gum or nicotine patch? If Yes, provide details: Product Type(s) Date Last Used Frequency of Use	The state of the contraction of the state of		
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BENEFITACCESS RIDER SUPPLEMENT

Supplementary Declarations Forming a Part of the Application For Insurance

Jarobarra Othicas, Newson, New Jaron; Pruco Life Insurance Company

a Prudential Financial company

POLICY NUMBER (IF KNOWN): V2353442	
100	

PRIMARY PROPOS	SED INSURED: SASIKALA NARRA	*				
A. MEDICAL H	ISTORY					
	r of the medical profession ever trea					
a. amyotrophi	c lateral sclerosis (ALS, Lou Gehrig's	s Disease), Huntingt	on's chorea, ataxia, tra	nsverse myelitis or		
myasthenia				16	☐ Yes	IXI No
b. chronic, red	Eurrent, or persistent memory loss or	confusion; senility,	cognitive impairment, o	lementia or organic brain disease?	☐ Yes	EE No
c. amputation	of more than one limb?				Yes	DO No
d. more than (one transient ischemic attack (TIA, i	min <u>i stroke)?</u>		- 6	Yes	IXI No
e: osteoporosi	s with compression fracture(s) or ot	her related fracture	(s), post polio syndrome	or chronic pain syndrome?	☐ Yes	EXI No
•	st 2 years, have you:					
	ed by a member of the medical profe		_		☐ Yes	⊠ No
	than once, been in a long term can	e facility, nursing ho	ome, required the servic	es of a home health care provider,		
or attended		☐ Yes				
c. been declin	ed for long term care insurance inc	luding coverage offe	ered as a rider to a life i	nsurance or other policy?	☐ Yes	⊠ No
3. Do you curren	· ·					
	ve you been advised to receive, help		personal hygiene, toilel	use, eating, taking medication,		
	or dut of a bed or chair, walking, dre	-			☐ Yes	_
	ichair, motorized scooter, walker, qu				Yes	III No
	or supervision with laundry, cleaning		he telephone, meal prep	paration, managing finances,		
	your médication, use of transportat	ion or yard work?			☐ Yes	
	long term care benefits?				☐ Yes	DZI No
e. have or hav	ve you applied for a handicap placa	rd or handicap licer	ise plate?		☐ Yes	DE No
				agnosis/condition, date, treatment	t, and the	name,
	ephone number of all attending p	the same of the sa		Line Latt Berlin		
Question #	Diagnosis/Condition	Date	Treatment	Physician/Hospital Name, Add	iress & Ph	one Number
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ORD 96200-2013AP BENEFITACCESS RIDER

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PART 2		
A. PERSONAL PHYSICIAN INFORMATION		
Name SURENDRA SHETH		
	052	
City MARLTON State NJ ZIP 08 Telephone number: (856) 985-3700 Date last seen: 09/2014	<i>)53</i>	
Reason last seen: GENERAL CHECK UP		
If more than one personal physician, provide details in section D number 6.		
B. PHYSICAL MEASUREMENTS		
1. Height: 5 feet 4 inches Weight: 176 pounds		
2. Within the last 12 months, have you had a change of weight (gain or loss) of more than 10 pounds? If Yes, provide details:	□ Yes	⊠ No
C. FAMILY HISTORY	····	
 Have any immediate family members (mother, father, brother, sister) been diagnosed with or died from coronary artery disease cerebrovascular disease, diabetes or cancer before age 70? If Yes, provide details including which member and medical condition, age at diagnosis, and age at death (if application) 	□ Yes	DSJ No
2. Father: Current age 64 or Age at death: Mother: Current age 62 or Age at death:		
D. MEDICAL INFORMATION		
1. Has a member of the medical profession ever treated you for or diagnosed you with:	i.	
a. high blood pressure, chest pain, a heart attack, coronary artery disease, a heart valve disorder, a heart murmur, an irregular heart beat, cerebrovascular disease, a stroke, circulatory disease, an aneurysm or any disease of the heart or blood vessel.		⊠ No
b. anemia or other abnormality of the blood (other than HIV)?	S; ⊔ les	DED No
c. a polyp, cyst, tumor, cancer, leukemia, melanoma, lymphoma or Hodgkin's disease?	□ Yes	⊠ No
d. diabetes, high blood sugar, glucose intolerance or other endocrine disorder?	☐ Yes	IXI No
e. anxiety, depression, or any other mental or psychiatric illness?		DO No
f. Acquired immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or any other sexually transmitted disease		
(other than HiV)?	☐ Yes	DO No
g. asthma, emphysema, cystic fibrosis, sleep apnea, sarcoidosis, tuberculosis or any other disorder of the lungs	_ ,	- A
or respiratory system?	☐ Yes	DZI No
h. a seizure, epilepsy, multiple sclerosis, Parkinson's disease, muscular dystrophy, cerebral palsy, paralysis, Alzheimer's diseor any other, disorder of the brain or nervous system?	ase 🗀 Yes	IVI No
i. an ülcer, hepatitis, cirrhosis, pancreatitis, ulcerative colitis, Crohn's disease or any other disorder of the esophagus, liver,		TET 140
stomach or intestines?	□ Yes	₩ No
j. nephritis, polycystic kidney disease or any other disorder of the bladder, kidney, urinary tract or prostate?	☐ Yes	™ No
k. arthritis, gout, back trouble, or any disease or disorder of the joints, muscles or bones?	□ Yes	™ No
1. lupus, rheumatoid arthritis, chronic fatigue syndrome, fibromyalgía, or any other disease or disorder of the autoimmune s	ystem? 🗆 Yes	™ No
2. Have you ever used:		
 a. cocaine, crack, marijuana, heroin, Ecstasy, PCP, LSD, methamphetamine, any other hallucinogenic drug or controlled sub b. amphetamines, barbiturates, sedatives, opiates or methadone, or controlled substance except as prescribed by a physicia 		
3. Have you had or been advised to have treatment or counseling for alcohol or drug use or been asked to reduce or eliminate	11	_ ••
their usage?	□ Yes	DXI No
4. Other than what has already been disclosed, within the past 5 years, have you:	_ ,,	_ ,,
a. requested or received disability or compensation benefits?	☐ Yes	
 b. been a patient in a hospital or other medical facility, other than for normal childbirth? c. had any other disease, disorder or condition? 	□ Yes □ Yes	
 c. had any other disease, disorder or condition? d. been advised to have surgery, medical tests or diagnostic procedures (other than for HIV)? 	⊔ res □ Yes	94
5. Are you currently receiving medical treatment or taking any other medication or herbal supplement that has not already	U 163	140
been disclosed?	☐ Yes	DET No
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AGREEMENTS

By signing this form, I have carefully reviewed the application including all supplements attached to the policy, and I agree to the following-

To the best of my knowledge and belief, the statements in this application are complete, true and correctly recorded.

- Except for failure to pay premium, the validity of this policy will not be contested after it has been in force during the insured's lifetime for two years from the date if takes effect.
- If I have requested the Acceleration of Death Benefits (Living Needs Benefit), I have read the disclosures in the Living Needs Benefit brochure.
- My original signature has been affixed to this application, the original will be retained by the Company named at the beginning of this application ("Company"). The copies attached to the policy issued to me are identical in form and substance

Any policy issued on this application shall not take effect until after all of the following conditions are met.

- A payment equal to the full first required premium is received by the Company within the lifetime of the proposed insured. A payment will only be considered to be received if one of the following valid items is received by the Company: (i) a check in the amount of the full first required premium; (ii) a completed and signed payment form for the first full premium; or (iii) any other form of payment acceptable to the Company.
- The form of payment submitted is honored. If payment is made by credit/debit card, wire transfer or automatic bank draft, no premium is considered to be honored until the Company actually receives the funds unless otherwise provided by applicable law.

A signed copy of this Application is received by the Company.

- The Owner has personally received the policy during the lifetime of and while the health of the Proposed Insured is as stated in this application.
- Only an officer of the Company with the rank or title of Vice President may make or alter any contract or agree not to enforce any of the rights of
 the Company, and then only in writing. No producer or medical examiner is authorized to accept risks, pass on insurability, make or after
 contracts, or waive any of the other rights or requirements of the Company. Notice to or knowledge imputed to any producer or medical examiner
 will not be notice of or knowledge to the Company unless it is set out in writing in this application.

FRAUD WARNING

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

SIGNATURES			<u> </u>		
Owner's Tax Certification (check boxes ONL	Y if applicable).		, 	 -	
Under penalties of perjury, I certify that the	taxpayer identification nu	nber (TIN) I have listed	on this form is my corr	ect TIN. I further certi	fy that I am
a U.S. person (including resident alien), ar	d I am not subject to backu	p withholding under Se	ction 3406(a)(1)(C) of	the Internal Revenue	Code.
☐ I have been notified by the Internal Rev	enue Service that I am sub	ect to backup withholdi	ng due to the underre	porting of interest or o	dividends
I am not a U.S. person (including resid	ent alien). You must submit	the applicable Form W-	-8 (BEN, BEN-E, ECI, E	XP or IMY); In most ca	ises, Form
W-8BEN will be the appropriate form.				4	
	evenue Service does not re ther than the certification			aocument	
Signed at (STATE) <u>NEW JERSEY</u>	·	on (DATE)	09/02/15	12	
Signature of proposed insured X X	الهلا				
If policyowner is different from the propos For a personal policyowner(s): Signature of policyowner(s) X	ed insured:		12		74
For an entity policyowner(s) (f.e., trust, busin Name of entity Signature of officer/trustee(s)					59
→ Signature of officer/trustee(s) X					· ·
Title of officer/trustee(s)		4.)	820	V V V	
Signature of producer X					

ORD 96200-2010 NEW JERSEY

Fax: 7325651216

EXHIBIT C

Case 2:18-cv-14793-ES-CLW Document 15-3 Filed 01/31/19 Page 17 of 31 PageID: 125

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Female	3. Social Securit	TE .	4a. Age 38 Years		RFI	Date of Birth (No/Dey/Yr)	
6 Birthplace (City & St Vijayawada, Andhri	a Pradesh, India	1						
7a Residence-State New Jersey	7	b County Burlington		7c. Municipale Maple Shad	yiCity le Township	- 1		
7d. Street and Number 3 Hamilton Road		West.	7e Apt No.		Zip Code B052		Inside City Limits?	Ι.
Sa. Ever in US Armed No 10	Forces7 &	b If Yes Name of Wi	ar E	ac War Servic	a Dates (Fron	MJO).	D.	
9. Comestic Status at 1 Married 1	Time of Death		of Surviving Spouse antharoa Marrá	Partner (Name p	nen at beth o	on birth certific	ate)	67 61
11. Father's Name (Fir	rst, Middle, Leal)		SIMISIAE MONIN			541	13,5	G.
 Venkateswarao Sul 12. Mother's Name Pri 	or to First Marriag	pe (First, Middle, Last)					+
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17. Name and Comple	te Address of Fur		Name Back Sed Address			(3)		\dashv
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23. Occupation of Dec			even if retired) 24	Kind of Busines	siladustry	163	44	13
Software Engineer 25. Name and Address	s of Last Employe	r .		Information Tuc	mno rogy	100	N/A	1
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31. Date of Death (Mo	8	Time of Death (24-A	·	dical Examiner Co	ontacted?	34 Place of D	2.9	
03/23/2017 C 35a Facility Name (If a		Approx-1538 a street and number)	Yes			Decedent's	Home	_
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FEATURED

\$25K Reward Offered for Information About New Jersey Software Engineer Sasikala Narra's Murder

SUNITA SOHRABJI, India-West Staff Reporter Sep 8, 2017



A \$25,000 reward has been offered for information about the murder of Indian American software engineer Sasikala Narra, who was found dead last March in her Maple Shade, New Jersey, apartment, alongside her six-year old son, IRED "We're hoping that this would be an incentive for someone to come forward with information," Joel Bewley, spokesman for the Burlington County, New Jersey prosecutor's office, told **India-West**. (Burlington County Prosecutor's Office photo)

8/24/2018 \$25K Reward Offered for Information About New Jersey Software Engineer Sasikala Narra's Murder | Global Indian | Indiawest.com

A \$25,000 reward has been offered for information leading to the arrest and conviction of persons involved in the murder of Indian American software engineer Sasikala Narra and her six-year-old son, $A_{\text{ACTE}}^{\text{RED}}$ who were found dead in their Maple Shade, New Jersey, apartment on March 23.

Narra, 38, and A^{REDA}_{CTED}were found slain in the bedroom of their home by Narra's husband, Hanumantha Rao. Both mother and son had been stabbed multiple times, Joel Bewley, spokesman for the Burlington County, New Jersey Prosecutor's Office, told **India-West**.

"We're hoping that this reward would be an incentive for someone to come forward with information," said Bewley, noting that the investigation was "very active and ongoing." Police have been going door to door in the community where Narra and her husband Hanumantha Rao lived with their son, passing out flyers offering the reward printed in Hindi, Telugu, Spanish, and English.

Bewley thanked the Indian Cultural Center in Evesham, New Jersey, for helping to translate the flyers into Hindi and Telugu.

Rao found the bodies of his wife and son on the evening of the murder, and called 911. He told dispatchers he did not know what had happened, as he had just returned home after "happy hour" after work with some of his co-workers from Cognizant.

Questioned by detectives, Rao said he could not remember whether he had used his key to get into the apartment, a key question in the case which would determine whether there was breaking and entering into the apartment.

In the 911 call released by Maple Shade police, an unidentified woman's voice can be heard in the background. When the 911 dispatcher asked Rao if he could perform CPR on his wife and child, the woman screamed: "No you can't. Their throats are slit."

She can also be heard on the recording telling Rao: "Don't go back in there."

Rao was believed to have been having an affair with Deepa Ajit, who also works at Cognizant's office in India. Narra had allegedly confronted her husband about Ajit: Rao allegedly told his wife there was no harm in an extramarital affair.

Bewley told **India-West** he could not state whether Rao and Ajit were under investigation. He also could not state whether there was any new information on how Rao entered the apartment that night or whether Ajit was in the U.S. at the time, saying the release of such information would

8/24/2018

\$25K Reward Offered for Information About New Jersey Software Engineer Sasikala Narra's Murder | Global Indian | Indiawest.com compromise the integrity of the investigation.

REDA Both Rao and Ajit were questioned by police after Sasikala and A CTED bodies were found. The Telugu Association of North America raised funds to have their bodies returned to Vijayawada for the final rites.

Rao did not attend the funeral of his wife and son, though his passport had not been confiscated (see earlier India-West story here).

What is your reaction? 2 votes Powered by Vuukle unmoved amused excited sad happy angry 0 comments Recommend 0 Write a comment

Name OF Email

I agree with Vuukle's Privacy Policy

TALK OF THE TOWN 1



Sikh Asylum Seekers Allegedly **Tortured at ICE Detention** Facility in Georgia

3 comments







Nation Mourns Vajpayee's Death: 'India Has Lost a Great Son

2 comments





Priyanka Chopra-Nick Jonas Eniov a Dinner Date in Mumbai

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EXHIBIT E



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Life Insurance Claim Form

GETTING STARTED: If you have any quastions about completing this form, please refer to the instructions that begin on page 5 or contact us at 890-496-1035. REMEMBER: Each beneficiary must complete and submit a separate claim form. Only one death certificate with a raised state seal is needed.	It's Prudential's responsibility to contact all named beneficiaries on the policies provided
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Hanumantharao Narra	
Name (First, Middle, Last) 5090 Beatty St	
Street Address	Apt/Sulte (optional)
Piscataway NJ 08854	
City, State, Zip	1.1.1
856 236 4402	
Home phone Mobile phone REDACTED	Email address REDACTED
HUSBAUIS 1979	/ /
Relationship to deceased	SSN, TIN or EIN
am the (check one): Geneficiary - Person named to receive funds from the policy	See page 5 of the instructions for the information regarding the appropriate TIN or EIN.
Power of Attorney for beneficiary (Attach Power of Attorney documentation	n)
Representative of the insured's estate (Attach a copy of proof of appointment)	ent)
☐ Trustee (Attach a copy of the trust agreement) Name of trust	
Check if you are the sole trustee of a (ir)revocable trust, the trust can over the trust is not a lestamentary trust and the Altiance Account is the payor	ment option selected.
 Check if any beneficiaries are considered a "skip person" by the Internal Information. 	Révenue Code. See instructions for more
Legal guardian for the benéficiary (Atlach a copy of the court order namin if the beneficiary is a minor provide minor's name and date of birth.	eg you as guardian)
First name MI Last name	Date of birth (mm/dd/yyyyy)
Assignee (Specify amount you are claiming)	
Other (Please specify)	
mplete and return this page.	page 1 of 9

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Life Insurance	Claim Form	http://LifeInsurance.Prudential.com
2. About the Provide information abo		e not aware of any other names, leave that line blank.
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DACTED 1978	03/23/	
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Provide all the policy number and may include tetter of	nder(s) for which you an refixes (e.g., x)2345678	e making a claim. The policy number(s) will be an & or Sociali muraber
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Policy number(s)		

4. How to Receive Your Funds

<u>In order to meatypour specific receis, we effer several payment outless les you te receive your life insurance death. Benefits</u>

Most Prudential policies offer several payment and settlement options that you should consider before making any election. If you would like detailed information about those options, please see pages 6-8 of this form or contact your Prudential Representative or customer service office at 800-496-1035. We also understand that this may be an emotionally challenging time in life and making financial decisions can seem overwhelming. To help make one decision easier for you, your eligible death claim benefits will be paid by the way of the Alliance Account (unless you elect an alternative payment or settlement option), where your money will earn interest until you're ready to make decisions about how to use the funds. For complete information and eligibility details about the Alliance Account, read pages 6 and 7 of this form. The minimum interest rate that will be paid on the Alliance Account will be no lower than 0.5% and may be as high as 3,5%. (The current rate, as of the date this form was mailed to you, is 1.50 %.) This rate may differ if you already have an existing open Alliance Account. The higher rate will prevail.

If you would like to select an alternative option, including a single lump sum check, indicate it here (as described in Understanding Your Options on Page 8 of the Instructions), Write your selection below:

For the Alliance Account settlement option, described on pages 6 and 7, please feave this line blank.

NOTE: You can also pay the funeral home directly. You must allach a copy of the funeral home assignment with this form to do so. Any remaining proceeds will be applied based on your selection above.

Complete and return this page, COMB 388 N1 Ed. 2/2017

Sacikala Harra

page 2 of 9





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Life Insurance Claim Form

se complete the following if you sel ains payable upon your death will be lecease you, any balance will be pai	e Account or other payment option) ected a payment option other than the single paid to those below. If you do not design to your estate. NOTE: If the Affiance A	ngle lump sum check above. Any amount the gnate any beneficiaries, or if all beneficiaries account was selected as the payment option accessor Trustees must be named in the
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Relationship to you	Telephone	Email address
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Life Insurance Claim Form	http://Lileinsurance.Prudential.com	9
6. Tax Certification Plasse complete day applicable portions of (a) or (b) below. Ma	lka süre, võu, hava Inekoded sout SSN/F(N in Section 1.	֧֧֧֧֧֧֓֝֝֟֝֝֟֝֝֝֓֓֓֝֝֞֝֓֓֓֓֓֡֝֡֝֡֝֡֝֡֝֡֝֡֝֡֝֡֝֡֝֡֝֡֝֡
(a) Under penalties of perjury, I certify that: • I am a U.S. person (including resident alten);	THE PARTY OF THE P	ى ل ئ
 The Social Security/Tax Identification Number provided is my correct SSN/TIN; 	in "Section 1. About You" on this form	σ
 I am not subject to FATCA reporting; and I am not subject to backup withholding due to failure to in the Tax Certification section). 	report interest or dividend income (see "Backup Withholding"	V
backup withholding due to failure to report interest or divide I am subject to FATCA reporting	1.00	N N
 I am subject to backup withholding due to failure to rep 		וויו טג
(b) I am not a U.S. person (including resident alien). I am a citi Attach the applicable IRS Form W-B (BEN, BEN-E, EC), EXI		¥.
7. Authorization to Release Informal	ion	}
I authorize Prudential or its authorized representatives to disclos the claim status and the amount of insurance benefit proceeds, representatives, and assignees of the insurance benefits or in re processing and payment of claims in an efficient and prompt m completed claim forms and documents to appropriate associate affiliates or business units for which a claim for payment or distr	in its explanation of benefits to beneficiarles, funeral home exponse to inquires from these individuals. For the purpose of anner, I authorize Prudential to consolidate and disclose is for each and every one of Prudential Financial, Inc.'s	1 0
8. Signature		88
I have read and agree to sections 1 through 7 and the Claim Fra form, I certify that information that I have provided is true and co result of this request.	implete. I understand that there may be tax implications as a	•
FLORIDA RESIDENTS - Any person who knowingly and with statement of claim or an application containing any false, incomp degree.	plete or misleading information is guilty of a felony of the third	
NEW YORK RESIDENTS - Any person who knowingly and wi lites an application for insurance or statement of claim containing misleading information concerning any fact material there to, cor also be subject to civil penalty not to exceed five thousand dollar the internal Revenue Service does not require your consent to an required to avoid backup withholding.	g any materially false information, or conceals for purpose of mmits a fraudulent insurance act, which is a crime and shall s and the stated value of the claim for each such violation.	
Havy new true ways Beneficiary's or Claimant's signature	05 07 2017 Date (mm/dd/yyyy)	}
To be completed by Prudential Representative	Check here to select Field Office Delivery	
	Contact Number Field Office Code	
Daniel Linn 908-770-8521 19 Address to deliver proceeds (only needed if private or petached)	908-770-8521 TRNL	
1 To will Center 16th Floo	R East Brunswick NJ 0887	
nplete and return this page.	page 4 of 9	ń

Sasikala Harra



COMB 388 N1 Ed. 2/2017



Life Insurance Claim Form

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Life Insurance Claim Form http://lifeInsurance.Prudential.com					
4	. How to Receive Your F	unds (continued)]	
Pie rer pre and	nains payable upon your death will be paid edecease you, any balance will be paid to y	a payment option other than the f to those below. If you do not do your estate. NOTE: If the Alliance	single lump sum check above. Any amount that esignate any beneficiaries, or if all beneficiaries e Account was selected as the payment option I. Successor Trustees must be named in the	9:46 5	
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Co	implete this section if you would like taxes	withheld, if you do not make an	qualified plan distributions) y elections, we will not withhold lanes unless tax forms. If needed, these will be sent to you.		
_	Withhold federal income taxes from the tax	, ,	For additional Information, see the Tax Withholding Election Information section In the Instructions and Disclosures on		

Complete and return this page. COMB 38B N1 Ed. 2/2017

Sacikala Narra

page 3 of 9



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Claim Fraud Warnings

For residents of all states and jurisdictions except Alabama, Arizona, California, the District of Columbia, Florida, Kentucky, Louisiana, Majee, Maryland, New Hampshire, New Jersey, New York, North Carolina, Pennsylvania, Puerto Rico, Rhode Island, Texas, Utah, Vermont, Vinglaia, and Washington: WARNING -- Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or 🗠 knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulant, deceptive or misleading facts or information when filing an insurance application or a statement of claim for payment of a loss or benefit commits a fraudulent insurance act, is/may be guilty of a crime and may be prosecuted and ounished under state law. Penalties may include fines, civil damages and criminal penalties, including confinement in prison, in addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for purpose of misleading, information concerning any fact material thereto.

ALABAMA RESIDENTS -- Any person who knowingly presents a laise or freudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof

ARIZONA RESIDENTS -- For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

ARKANSAS, DISTRICT OF COLUMBIA, LOUISIANA and RHOBE ISLAND RESIDENTS -- Any person who knowingly presents a faise or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

CALIFORNIA and TEXAS RESIDENTS -- For your protection, California and Texas law requires the following to appear on this form, Any person who knowingly presents a false or fraudulent claim for the payment of a loss is quilty of a crime and may be subject to lines and confinement in

KENTUCKY RESIDENTS -- Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially talse information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime

MAINE and WASHINGTON RESIDENTS -- Any person who knowingly provides false, incomplete, or misteading information to an insurance company for the purpose of detrauding the company commits a crime. Penalties include imprisonment, fines, and denial of insurance benefits.

MARYLAND RESIDENTS -- Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in

NEW HAMPSHIRE RESIDENTS -- Any person who, with purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance traud, as provided in

NEW JERSEY RESIDENTS -- Any gerson who knowingly files a statement of claim containing any lafse or misleading information is subject to criminal and civil penalties.

NORTH CAROLINA RESIDENTS -- Any person who, with the intent to injure, defraud, or deceive an insurer or insurance claimant, presents or causes to be presented a written or oral statement, as part of, or in support of, a claim for payment or other benefit pursuant to an insurance policy, knowing that the statement contains false information concerning a fact or matter material to the claim may be guilty of a Class H felony

PENNSYLVANIA and UTAH RESIDENTS -- Any person who and with intent to defraud any insurance company or other person files an application for insurance or statement containing any materially false information or conceals for the purpose of misleading, information concerning any material fact thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties

PUERTO RICO RESIDENTS -- Any person who knowingly and with the intention of defrauding presents false information in an insurance application or presents, helps, or cause the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars (\$5,000) and not more than ten thousand dollars (\$10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances (be) present, the penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

VERMONT RESIDENTS -- Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law.

VIRGINIA RESIDENTS -- Any person who, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

Do not return this page with completed form. COMB 388 N1 Ed: 2/2017

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The Prudential Insurance Company of America Pruce Life Insurance Company of New Jersey Pruce Life Insurance Company
All ere Prudential companies.
http://LifeInsurance.Prudential.com

Quick Start Guide

What you'll find in this package

- Life Insurance Claim Form -- Please complete, sign and return this form to start the claim process.
- Affiance Account information -- We also explain this flexible, convenient option for receiving your claim
 proceeds throughout the package

Note: On these pages, 1, you, and your refer to the person making the claim. We, us, and our refer to the Prudontial company that issued the policy.

To submit your claim, follow these steps:

1. Decide how to receive your funds

Be sure to select a payment option when you complete the form. Your options include:

- Open an interest-bearing Alliance Account that offers immediate access to your funds together with draft-writing privileges. When your claim is paid by way of the Alliance Account, you can take as much time as you need to consider important financial decisions, while earning interest. Additionally, accessing your funds is as simple as writing a draft to yourself or anyone else. (Certain businesses may have their own policies and procedures for accepting drafts.) The account begins earning interest from the day it is opened, You can leave the funds in your account for as long as you like, access any or all of your funds, and transfer funds to another available settlement option at no cost and at any time. Read more about the Alliance Account on pages 6-7 of the Life Insurance Claim Form for more information.
- Elect to receive a single lump sum check by mail.
- Select another payment option as described on page 8 of the form. If you would like more information on the
 payment options available to you, please call 800-496-1035 to request the Your Options brochure.

Note: You can also use proceeds to pay the funeral home directly. You must submit a copy of the funeral home assignment with the claim form to do so.

2. Complete the enclosed form

Fill out the enclosed Life Insurance Claim Form that begins on the next page. Please follow the instructions and provide all requested information for prompt claim processing.

3. Return the signed claim form and supporting documentation

Please mail pages 1-4 of your claim form, as well as any additional documents that may be required. Including a death certificate with a raised state seal to:

Reguler mail Potosniel Alterbook 16 Jams P.C. Box 70174 Phispalobas, PA 19176

Express mail
Photennel
Attention, Life Crain 1
2101 Weish Bried
Dresher PA 19025

What to expect after submitting your form

We're committed to processing your claim as quickly as possible. Once we receive and verify all your information, we're typically able to process a claim within 5-7 business days.

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EXHIBIT F



OFFICE OF THE PROSECUTOR COUNTY OF BURLINGTON

PO BOX 6000 MOUNT HOLLY, NEW JERSEY 08060

> PHONE (609) 265-5035 www.burlpros.org



Phillip Aranow FIRST ASSISTANT PROSECUTOR

DARREN ANDERSON CHIEF OF INVESTIGATIONS

Scott A. Coffina
BURLINGTON COUNTY PROSECUTOR

To: Mary Kelly-Prudential Life Insurance

From: Assistant Prosecutor Robert S. Van Gilst

Ref: Sasikala Narra Policy # V2 353 442, L9 201 428

Date: 05/31/2017

To Whom It May Concern:

This letter shall serve as notification that as of this date, that the death of Sasikala Narra is an open criminal investigation therefore no parties can be conclusively eliminated at this time.

Sincerely,

Assistant Prosecutor Robert S. Van Gilst

Burlington County Prosecutor's Office

Major Crimes Unit Supervisor

APPELLATE UNIT INFORMATION SYSTEMS UNIT FAX (609) 265-5994

BURLINGTON COUNTY LAW ENFORCEMENT TRAINING CENTER FAX (609) 726-7272

CHIEF OF INVESTIGATIONS INSURANCE FRAUD UNIT MAJOR CRIMES UNIT PUBLIC INFORMATION OFFICER VICTIM WITNESS UNIT FAX (609) 265-5586

CHILD ADVOCACY CENTER (CAC) FAX (609) 265-5906

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